

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER Lincoln Park Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 C A Becker Dr Racine, WI 53406	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility did not ensure they provided the appropriate treatment and services to 3 out of 4 (R26, R5, R86) residents reviewed for the development of pressure injuries.</p> <p>R26 was admitted to the facility with a pressure injury to the buttocks. The facility did not complete a comprehensive assessment of the pressure injury upon admission and did not obtain an order for treatment of the pressure injury until 2 days after the admission.</p> <p>R5 was readmitted to the facility after a hospital admission and R5's Stage 4 pressure injury was not comprehensively assessed on the day of readmission.</p> <p>R86 was readmitted to the facility on [DATE] following a hospitalization and the facility did not complete a comprehensive assessment of R86's skin until 6/2/26.</p> <p>Findings include:</p> <p>The facility's policy dated as revised 1/23/26 and titled Pressure Injury Prevention and Management documents: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure injury/injury, prevent infection and the development of additional pressure injuries/injuries.</p> <p>Policy Explanation and Compliance Guidelines(includes) :2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions; and modifying the interventions as appropriate. c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury, Findings will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor pain, tissue type in the wound bed) and treatment and interventions implemented.</p> <p>1.) R26 was admitted on [DATE] with diagnoses that included Hypertension, acute respiratory failure, Diabetes Mellitus type II and Pneumonia.</p> <p>R26's nursing note dated 4/11/2026 at 7:05 PM and written by Licensed Practical Nurse (LPN)- I documents: (R26) recently admitted w (with)/rehab and strengthening d/t (due to) generalized weakness and deconditioning r/t AMS (altered mental status), hypoxia, tachypneic w/ tachycardia requiring intubation IV (intravenous) [NAME] (antibiotics) and vasopressor therapy. After transferred (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>out of ICU (intensive care unit) pt (patient) found unresponsive w/ mult (multiple) acute infarcts. Alert and oriented; able to make needs known. Skin warm dry w/ adequate turgor. No tenting, dry oral mucosa or obvious signs of dehydration. Dressing to buttocks CDI (clean, dry, intact). Some swelling to bilat (bilateral) upper thighs. No BLE (bilateral lower extremity) edema. INC of B&B (incontinence of bowel and bladder). Requires extensive assist w/repositioning, cares and transfers x2 (2 staff) w/lift. Appetite good; eating 75% of dinner. Currently no indications or c/o (complaints of) increased pain or discomfort. All safety precautions in place per POC (plan of care). PMD (primary medical doctor) updated and all orders verified. Will cont. (continue) to eval (evaluate) and anticipate pt needs.</p> <p>R26's Advanced Clinical admission Assessment, dated 4/11/26 at 7:55 PM documents: (R26) has a skin issue- location: coccyx. Laterality/ Orientation: Medial. Issue type: pressure. Progress: stable. previously deteriorating wound characteristics plateaued. Pressure injury staging: Stage 3 - full thickness skin loss. Wound was present on admission. Length 3.6 cm x 3.4 cm width and 0 undermining. There are no additional characteristics, tissue type, or wound bed details documented.</p> <p>Surveyor reviewed the discharge summary from the hospital dated 4/11/26. Surveyor noted that there were no instructions regarding the care and treatment of a coccyx pressure wound. The hospital problem list did not include R26 having a pressure injury to the coccyx and the discharge medication list did not include any type of treatments for R26.</p> <p>R26's Braden Skin assessment dated [DATE] (assessed the risk of developing a pressure injury) documents a score was 15 points, indicating R26 is at risk for pressure injuries.R26 has potential for impairment to skin integrity r/t (related to) decreased mobility documents: admission: Unstageable; bilateral buttocks Date Initiated: 04/11/2026.The resident will remain free of new skin impairment through the review date. Date Initiated: 04/14/2026.Under the Interventions section it documents:</p> <p>Air Mattress; set to weight and/or comfort level. Initiated: 04/11/2026Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date Initiated: 04/11/2026Use wedge to improve positioning. Date Initiated: 04/11/2026Wheelchair pressure reduction cushion. Date Initiated: 04/11/2026Encourage resident to wear bilateral heel boots when in bed. Date Initiated: 04/18/2026Encourage that heels are elevated while resident is lying in bed. Date initiated: 4/11/26</p> <p>R26's nursing note dated 4/13/2026 at 08:00; AM documents: Skin Check Skin: Skin warm & dry, skin color WNL and turgor is normal. R26 does not have an external device. Foot evaluation completed. Skin Issues: Skin Issue: 001: New skin Issue. Location: Buttocks - generalized. Laterality / Orientation: Right. Laterality / Orientation: Left. Additional location information: bilateral buttocks (medial) Issue type: Pressure injury / injury. Progress: New: new wound. Pressure injury staging: Unstageable pressure injury / injury. Unstageable injury due to slough and / or eschar. Wound was present on admission. Staged by: In-house nursing. Length (cm): 3.6 Width (cm): 3.4 Depth (cm): 0. Skin Issue: #002: New skin Issue. Location: Front left thigh. Issue type: Other skin issue. Other skin issue description: scabs Progress: New: new wound. Wound was present on admission.</p> <p>R26's physician order dated 4/13/25 at 8:15 AM documents: Buttocks: Cleanse bilateral buttocks with NS, apply xeroform and bordered gauze everyday shift for wound care AND as needed for wound care.</p> <p>R26's physician order dated 4/13/26 at 2:00 PM documents: Monitor bilateral buttocks for changes in skin alteration, report changes to provider every shift for wound care.</p> <p>Surveyor conducted a review of the Treatment Administration Record for April 2026. Surveyor noted (continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>that there was no physician order for the treatment of the pressure injury to R26's buttocks until 4/13/26, or two days after R26 was admitted .</p> <p>Surveyor also noted that there was no documentation in R26's TAR for April 2026 that treatment was provided to R26's pressure injury until 4/14/26, or three days after R26 was readmitted to the facility.</p> <p>R26's nursing note dated 4/15/2026 at 11:40 AM documents: Adv - Skin Issues: Skin Issue: #001: Skin issue has been evaluated. Location: Buttocks - generalized. Laterality / Orientation: Left. Laterality / Orientation: Right. Additional location information: bilateral buttocks (medial) Issue type: Pressure injury / injury. Progress: Improving: overall wound characteristics improved. Length (cm): 4.17 Width (cm): 4.53 Depth (cm): 0 Area (cm2): 10.48 Undermining: No. Tunneling: No. Odor after cleansing: None. Surrounding tissue: Intact. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Minimal < 25%.</p> <p>On 4/16/26, R26 had an initial assessment with the Wound Physician. The following was documented: presents with wounds on her/ his left buttock, right buttock and left anterior thigh. Left Buttock-unstageable /necrosis. Present less than 1 day. Measures 6 x 4 x 0.1 cm with a surface area of 24 centimeters. 80% necrotic tissue and 20% granulation tissue. No pain is present and no signs of infection. Treatment: xeroform gauze apply once daily and as needed if saturated soiled or dislodged. Gauze island with border apply once daily and as needed. Debridement procedure. Right Buttock-unstageable due to necrosis. Present less than 1 day. Measures 4 cm x 4 cm x 0.1 cm. Surface area- 16 cm. 80 % necrotic tissue and 20 % granulation tissue. No pain and no signs of infection. Debridement procedure. Treatment same as above.</p> <p>On 4/22/26 at 9:20 AM, Surveyor interviewed DON (Director of Nursing)-B regarding R26 being admitted on [DATE] with a pressure injury to the buttocks. Surveyor asked DON- B about the facility not conducting a comprehensive assessment of the wound on 4/11/26 and also not obtaining a treatment order. DON- B stated that R26's room was already set up for R26's arrival and an air-mattress was in place for R26. DON-B stated that the nurse who admitted R26 to the facility observed a treatment in place on R26's buttocks when completing the head-to-toe assessment. DON- B stated that the nurse removed the dressing and measured the area and then replaced the dressing with a new/clean treatment that R26 had in place upon his arrival to the facility.</p> <p>Surveyor asked DON- B how the nurse knew what treatment was in place prior. DON- B stated that the nurse replaced it with the equivalent in what was in place prior. DON- B stated that typically staff would be expected to call the Doctor/ Nurse Practitioner and either get clarification for a treatment or get a new order for a treatment when a wound is observed. DON- B stated that because there was a dressing in place from the hospital, the nurse just put the same type of dressing back in its place. DON- B also stated that the dressing can be in place for up to 72 hours and this is how long it was going to be before the facility's wound nurse was going to assess the pressure injury.</p> <p>On 4/22/26 at 11:25 AM, Surveyor interviewed Wound Nurse- C regarding R26's pressure injury to the buttocks. Surveyor asked Wound RN- C if a Registered Nurse has assessed R26's pressure injury upon admission on [DATE]. Wound RN- C stated that LPN-I assessed R26 and provided a measurement and staged the area. Wound RN- C stated that the RN on duty probably had other residents to take care of and she was not available to assess R26 on 4/11/26. Wound RN- C stated she told LPN- I to just put a new dressing on and she would assess it on Monday 4/13/26 when she returned to work. (continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/26 at 2:12 PM, Surveyor interviewed LPN- I regarding R26's admission on [DATE] and the assessment of the pressure injury to the buttocks. LPN- I stated that she was conducting a head-to-toe assessment of R26 and when the Certified Nursing Assistant and herself turned R26 over she noticed a dressing to R26's buttocks. LPN- I stated that there was nothing in the hospital paperwork that documented R26 had a pressure injury upon discharge from the hospital. LPN- I stated she took the dressing off and cleaned the area. LPN- I stated she then got her measuring tool and measured the area. LPN- I stated that she has been a nurse for 20 years and is familiar with pressure injuries. LPN- I stated she cleansed the wound with normal saline, patted it dry and applied a border gauze because that was what was in place prior.</p> <p>Surveyor asked LPN- I if she had called the Physician or Nurse Practitioner to obtain an order for treatment because there was no order in the hospital paperwork. LPN- I stated that she does not recall if she spoke with Nurse Practitioner or the Physician to get an order. LPN- I stated she had a lot of admissions that day and was very busy. LPN- I stated that she doesn't remember if she asked the Registered Nurse who was also working that shift to assess the area.</p> <p>Surveyor noted that R26's pressure injury did not have a comprehensive RN assessment upon admission and the facility did not document a physician order for treatment of the pressure injury until 4/13/26, or two days after R26 was readmitted to the facility. Despite this, Surveyor noted that R26's pressure injury remained consistent in size and staging.</p> <p>No additional information was provided.</p> <p>2.) R5 was admitted to the facility on [DATE] with diagnoses of paraplegia, diabetes, chronic pancreatitis, schizophrenia, and chronic obstructive pulmonary disease.</p> <p>R5's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R5 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and needed maximum to total assistance with activities of daily living.</p> <p>R5 developed a pressure injury to the left gluteal fold on 4/23/2025.</p> <p>On 7/2/2025 at 11:44 AM in the progress notes, nursing documented R5 was sent to the hospital for evaluation and treatment of the left gluteal fold wound which showed signs of infection with increased pain and foul-smelling drainage. R5 was agreeable to go out and be evaluated. R5 was noted to be non-compliant with offloading which is likely contributing largely to the decline in R5's wound. R5 was continually educated on the importance of offloading and proper nutrition.</p> <p>On 7/11/2025, R5 was readmitted to the facility. On the Nursing Evaluation form, Licensed Practical Nurse (LPN)-G documented in the Skin Integrity section R5 had a decubitus ulcer to the left buttock. No measurements or wound characteristics were documented.</p> <p>On 7/14/2025, R5's left gluteal fold Stage 4 pressure injury was comprehensively assessed by the facility wound Registered Nurse (RN), three days after readmission.</p> <p>On 8/21/2025 at 7:20 AM in the progress notes, nursing documented R5 was using accessory muscles to breathe, and breathing was labored. R5's oxygenation on 3 liters of oxygen was 88%. The nurse increased the oxygen to 10 liters and R5's oxygenation increased to 95-98%. R5 was not arousable with sternal rub prior to the increase in oxygen administration and after the oxygenation increased, R5 (continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>wound as a pressure injury when it is a venous ulcer so the nurses have been instructed to just put the location of the wound on the form and then the wound nurse along with the wound physician would document the etiology of the wound so it was not entered in wrong the first time. Surveyor shared with DON-B the concern R5 was admitted to the hospital four times in the last year with a pressure injury and on readmission to the facility, the wound is not comprehensively assessed for up to four days after readmission. Surveyor shared the concern that without documentation on the day of readmission, the progression of the wound cannot be followed to know if it is improving or declining. DON-B agreed stating the system is broken.</p> <p>On 4/22/2026 at 1:37 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R5's Stage 4 pressure injury was not comprehensively assessed on four readmissions until one to four days after readmission. No further information was provided at that time.</p> <p>3.) R86 was admitted to the facility on [DATE] with diagnoses that included hypertension, cerebral infarction with right side hemiplegia, aphasia and dysphagia.</p> <p>R86's Minimum Data Set (MDS) dated [DATE] documents that R86 was assessed to be severely cognitively impaired and dependent with activities of daily living (ADL). The MDS also documents that R86 was assessed to be incontinent of bladder and bowel.</p> <p>R86's Care Assessment Area (CAA) dated 5/10/25 documents: R86 has decreased mobility requiring assistance for her mobility and repositioning which is a contributing issue for potential pressure ulcer development in addition to incontinence issue due to exposure of skin to moisture. (R86) is s/p (status post) hospitalization due to right hemiparesis and aphasia effected by left cerebral infarction resulting to generalized weakness and a decline in her functional status.Heels off bed, incontinence care and skin checks will be maintained per facility's protocol.</p> <p>R86's care plan dated 5/7/25 documents potential for skin impairment with an intervention of -Monitor skin when providing cares, notify nurse of any changes in skin appearance.</p> <p>R86's treatment administration record (TAR) for May 2025 documents reposition every 2 hours with start date of 5/7/25. The TAR also documents skin checks completed every Tuesday and Friday.</p> <p>R86's nurses note dated 5/23/25 documents: R86 developed a new open area to the coccyx.</p> <p>R86's Wound MD-H assessment dated [DATE] documents: pressure injury to the sacrum that presents as deep tissue injury (DTI) measuring 12 centimeters (cm) by 7 cm by 0.1 cm. A treatment was ordered for leptospermum honey applied to wound with foam bordered dressing three times a week.</p> <p>R86's nurses note dated 5/26/25 documents: R86 fell out of bed and was sent to the hospital.</p> <p>R86's hospital record dated 5/26/25 documents: R86 sacrum wound as unstageable measuring 10 cm by 4 cm with 10% slough. There is no further documentation from the hospital regarding R86 pressure injury</p> <p>R86 was readmitted to the facility on [DATE] with a readmission physician treatment order that documented: Medihoney with foam bordered dressing to be changed Monday, Wednesday and Friday. (continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor was unable to locate a comprehensive wound assessment for R86's sacrum unstageable pressure injury that was completed on 5/31/25 when R86 was readmitted to the facility.</p> <p>The facility completed a skin and wound evaluation dated 6/2/25 which documents: R86 sacrum pressure injury is unstageable measuring 13.3 cm by 10.3 cm with 100% slough. Surrounding tissue presents as denuded and erythema. It documents R86 was readmitted from the hospital with her wound to her sacrum substantially deteriorated.</p> <p>R86's care plan documents dated 6/2/25 documents air mattress implemented along with repositioning every 2 hours.</p> <p>R86's nurses note dated 6/2/25 documents: R86 had been refusing to eat and was pocketing crushed medications. R86's Power of attorney (POA) and Nurse practitioner (NP) were made aware. Discussion with R86's POA regarding R86 DNR status and R86 not eating and drinking was conducted. R86's POA was educated on the importance of nutrition and tube feeding was discussed. R86 POA stated R86 did not wish to have a feeding tube.</p> <p>R86's Wound MD-H assessment dated [DATE] documents: R86 sacrum pressure injury as unstageable necrosis measuring 10 cm by 5 cm by 0.1 cm. The assessment also documents (R86) requiring an increase in the level of care. Doxycycline 100 mg (milligrams) po (by mouth) X 14 days, probiotic 2 tabs daily for 30 days for cellulitis. The treatment was changed to cleanse with dakins 1/2 strength and apply alginate calcium followed by foam bordered dressing twice daily.</p> <p>Wound MD-H assessment dated [DATE] documents: R86 sacrum pressure injury as stage 4 measuring 10 cm by 5 cm by 6 cm with 100% necrotic tissue. Wound MD-H documents (R86) requiring an increase in the level of care. Recommendation ER for further evaluation and/or for debridement.</p> <p>The nurses note dated 6/13/25 documents R86 was sent to the hospital for evaluation of the sacrum wound. R86 did not return to the facility after this hospitalization.</p> <p>The hospital record dated 6/13/25 documents WBC (white blood cell) elevated to 23. Lactic acid elevated. Concerns for sepsis. Fluids ordered. Will start broad spectrum antibiotics.</p> <p>On 4/22/26 at 9:22 a.m. Surveyor interviewed DON-B. Surveyor explained to DON-B when R86 was readmitted to the facility on [DATE], a comprehensive wound assessment was not completed. A wound assessment was completed on 6/2/25. DON-B stated the wound nurse that was here while R86 was at the facility no longer works for the facility and DON-B can't answer why an assessment wasn't completed on 5/31/25. Surveyor asked DON-B what contributed to R86 wound deteriorating to the point of needing antibiotics. DON-B stated R86 had a poor appetite and R86's family did not want R86 to have a feeding tube.</p> <p>On 4/22/26 at 9:33 a.m. Surveyor interviewed Wound MD-H. Surveyor asked Wound MD-H what contributed to R86 pressure injury to deteriorate. Wound MD-H stated when R86 returned from the hospitalization on 5/26-5/31/25, R86 wound was brewing an infection deep internally but because they couldn't see the wound base due to the necrotic tissue, it was presenting as cellulitis and the antibiotic was not helping. Wound MD-H stated he recommended R86 be sent to the hospital on 6/13/25 because he could not debride the wound enough at bedside and R86 would need surgical debridement to treat whatever infection was underneath it. Wound MD-H stated he had no concerns with R86 being repositioned and interventions were in place to aid in healing of the pressure injury. (continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R86) of 3 sampled residents at risk for falls had interventions in place to prevent a fall with major injury. On 5/23/25 R86 sustained a fall out of bed and was sent to the hospital due to R86 being on a blood thinner and R86 being unable to vocalize if she hit her head. At the hospital R86 was found to have a left subacute infarct of left parietal and frontal lobe with petechial hemorrhage along acute infarct (brain bleed). R86 was at high risk for falls, had right sided weakness from a stroke, had contradictory assessments regarding bed mobility and interventions to be used, was on an anticoagulant and was on an air mattress which are risk factors for a fall. The facility did not assess the various risk factors and the need for possible interventions to prevent a fall with a major injury. Findings include: The facility fall prevention program dated 1/3/23 documents .5. Low/Moderate risk protocols: implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: Clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed, call light and frequently used items are within reach, adequate lighting and wheelchairs and assistive devices are in good repair. Implement routine rounding schedule, monitor for changes in resident's cognition, gait, ability to rise/sit, and balance, encourage residents to wear shoes or slippers with non slip soles when ambulating, .High risk protocols Implement interventions from low/moderate risk protocols, provide interventions that address unique risk factors measured by a risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. Provide additional interventions as directed by the resident's assessment including but not limited to: Assistive devices, increased frequency of rounds, sitter if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance .R86 was admitted to the facility on [DATE] with diagnoses including hypertension, cerebral infarction with right side hemiplegia, and aphasia. R86's admission Minimum Data Set (MDS) dated [DATE] documents R86 is severely cognitively impaired and dependent with activities of daily living (ADLs). R86 is always incontinent of bladder and bowel. R86 is dependent upon staff for rolling left to right in bed and transferring from bed to a chair. Other mobility assessments including sit to lying, lying to sitting on side of bed, and transfer to toilet were not attempted due to R86's medical condition and/or safety concerns. R86's Care Assessment Area (CAA) for pressure injuries dated 5/10/25 documents: R86 has decreased mobility requiring assistance for her mobility and repositioning which is a contributing issue for potential pressure ulcer development in addition to incontinence issue due to exposure of skin to moisture. (R86) is s/p (status post) hospitalization due to right hemiparesis and aphasia effected (sic) by left cerebral infarction resulting to (sic) generalized weakness and a decline in her functional status. R86's fall risk evaluation dated 5/8/25 documents a score of 7; a score of 5 or above is high risk for falls. The care plan for risk for falls related to right hemiparesis due to stroke, impaired mobility and general weakness dated 5/7/25 documents the intervention, Anticipate and meet the resident's needs. No other interventions are documented to prevent falls or ensure R86's safety due to their risk of falls and diagnoses that contribute to R86's safety risk from falls. R86's Activities of Daily Living (ADLs) Care Plan for the resident has potential for an ADL self-care deficit r/t (related to) generalized weakness initiated 5/7/25 with a goal of improving current level of function through review date initiated 5/8/25, target date 8/5/25. Bed mobility interventions: The resident is an assist of 1 with turning and repositioning in bed. Initiated 5/8/25 The resident uses enabler bars to maximize independence with turning and repositioning in bed. Initiated 5/8/25 The resident uses (SPECIFY assistive device) to maximize independence with turning and repositioning. Initiated 5/8/25 R86's care plan for cerebral vascular accident (stroke) affecting right side of body, aphasia, and intercranial (sic) (continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>hemorrhage initiated 5/8/25 with a goal to show improvement to maximum potential to perform ADL's by review date was initiated 5/8/25 with a target date of 8/5/25. This care plan includes an intervention to turn and reposition q (every) 2 hours and PRN (as needed) Keep body in good alignment. Initiated 5/8/25. A nurse's note dated 5/26/25 documents: Writer (Licensed Practical Nurse (LPN) N) was walking back to the nurse's station when the nurse's aide (sic) to the writer to hurry and come into the room. When writer walked into the room the resident was laying on the floor. Resident had RN assess the patient, vital signs were stable. No complaints of pain outside of the resident's baseline. Resident was sent out due to not being able to tell if she hit her head or not and being on blood thinners. POA (power of attorney) and NP (nurse practitioner) were notified, and NP gave writer permission to have her sent out for observation. Hospital record dated 5/26/25 documents R86 had a brain bleed and remained at the hospital until 5/31/25. The Hospital discharge documentation dated 5/31/25 documents for History of Illness/Hospital course: .history of CVA (cerebral vascular accident) causing right sided hemiparesis and aphasia. Patient was rolled onto her side for hygiene purposes and fell out of the bed at the SNF (skilled nursing facility). Patient on aspirin and Eliquis. EMS (emergency medical services) called and patient transported to the ER (emergency room). CT (computerized tomography) head with left subacute infarct of left parietal and frontal lobe with petechial hemorrhage along acute infarct. Kcentra (medication used for the rapid, urgent reversal of acquired blood coagulation factor deficiency caused by vitamin K antagonist (ex. anticoagulant medication) therapy in adults with acute major bleeding.) was given to reverse anticoagulation. admitted to ICU (intensive care unit). On 4/21/26 at 9:44 AM Surveyor spoke to R86's family member-R regarding R86's fall and need to go to the hospital. Family member-R stated they were told (R86) fell out of bed during cares because 1 CNA (certified nursing assistant) was working with (R86) instead of 2. R86 was readmitted to the facility on [DATE]. On 4/21/26 at 12:34 p.m. Surveyor interviewed Licensed Practical Nurse (LPN)-N. Surveyor asked LPN-N if she remembers any details of the fall R86 sustained on 5/26/25. LPN-N Referred to her documentation and stated she doesn't remember much about the incident. Review of the facility Fall details dated 5/26/25 at 11:06 am document the above nurse's note as a description of the incident. It is additionally documented the resident was unable to give a description and it was unwitnessed. Immediate action taken documents notified POA, DON (Director of Nursing), and NP. Got order to send her out. Helped put resident back into the bed. The report asks was resident taken to hospital? It is documented N (no). Surveyor noted this is despite R86 being transferred to the hospital. No injuries observed at the time of incident. No pain, Alert and wheelchair bound for mobility. Mental status: oriented to person and situation. Resident does not respond well to questions asked, speech is hard for her. None is documented for predisposing environmental factors. Predisposing physiological Factors document antianxiety use, confused, difficulty with communication, gait imbalance, incontinent, and weakness. Predisposing situation factors are documented as specialty bed. Surveyor noted the risk factors identified as predisposing factors were not assessed or addressed in a care plan prior to this fall. Surveyor noted the documentation does not include any statements or details from staff to accurately determine if the fall was witnessed or not and whether the fall occurred while providing cares as indicated in the hospital documentation. The verification of investigation for R86's fall dated 5/26/25 documents the nursing progress note as documented above regarding LPN-N being called into room while walking back to nurses station. Resident was unable to describe fall, BIMs (brief interview for mental status) 4/15 indicating severe cognitive impairment. Contributing factors and interventions documented include: CVA with affecting dominant right side, able to move independently in bed, high BMI (body mass index; weight (193-202). Modified interventions to the plan of care to prevent re-occurrence: upon return from hospital - staff to position resident with pillows to help identify perimeter of mattress. Summary of factual investigative findings documents: IDT (interdisciplinary team) met regarding fall on 5/26 in resident room. No injury occurred initially noted. Resident is receiving assistance with transfers, toileting, and ADLs (activities of daily living). Resident unable to state (continued on next page)</p>		

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